STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

GEORGE DEUKMEJIAN, *Governor*

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

April 6, 1990
Letter No.: 90- 35

TO: ALL COUNTY WELFARE DIRECTORS
ALL COUNTY ADMINISTRATIVE OFFICERS

SUBJECT: OTHER HEALTH COVERAGE

REFERENCE: ALL COUNTY WELFARE DIRECTORS LETTERS 87-44 AND 88-89

The Department of Health Services (DHS) will be conducting another file match with the California Public Employees Retirement System (PERS) to identify Medi-Cal beneficiaries currently insured with this program.

PERS contracts with several insurance carriers, all meeting the definition of full coverage; therefore, matched beneficiaries' Medi-Cal cards will be coded for cost avoidance. As a result of the data match, DHS will update the MEDS with the Other Health Coverage (OHC) cost avoidance codes of K, P, R, or V. These codes will be reflected on the beneficiaries' Medi-Cal cards. We expect to begin coding Medi-Cal cards for the April 1990 month of eligibility.

Affected beneficiaries will be sent a letter (enclosed) explaining cost avoidance, the data match and coding. The letter will also inform the beneficiary of one of the following requirements:

- If your Medi-Cal card is coded with "V", your providers will have to bill your private health insurance before billing Medi-Cal. If your insurance denies payment, your provider may then bill Medi-Cal; or,

- If your Medi-Cal card is coded with a "K", "P", or "R", you are identified as having health coverage provided through a prepaid health plan or health maintenance organization. Beneficiaries with this coverage are required to go to their specific health plan to receive health care services. If your prepaid health plan/health maintenance organization does not provide the needed service, you must request from the health plan a "Denial Letter" or "Explanation of Benefits" clearly stating the service requested is not covered under the terms of your health plan policy. Present the Denial Letter or Explanation of Benefits to your Medi-Cal provider so he/she can attach the letter to a Medi-Cal claim for reimbursement.

If private health insurance coverage extends to a dependent(s) on Medi-Cal, beneficiaries are now instructed to complete a Health Insurance Questionnaire, which will be enclosed with the letter, listing all Medi-Cal dependents covered by the plan and to return the questionnaire to the Department of Health Services. Beneficiaries are also instructed to contact their county welfare department in the event they no longer have the coverage now identified on their Medi-Cal card.

The list below will assist workers in using the correct cost avoidance PHP/HMO codes when a Medi-Cal applicant is identified as having OHC administered through PERS:

Health Plan Administered by PERS	Cost Avoidance Code
Kaiser North	K
Kaiser South	K
Bay Pacific Health Plan	P
Bridgeway Plan for Health	P
EQUICOR Health Plan	P
Family Health Program	P
Foundation Health Plan	P
French Health Plan	P
Greater San Diego Health Plan	P
HEALS Health Plan	P
Healthcare	P
Health Net	P
The Health Plan of America	P
Health Plan of the Redwoods	P
Lifeguard	P
Maxicare	P
PARTNERS Health Plan	P
Peak Health Plan	P
TakeCare	P
Travelers Health Network	P
ValuCare	P
Ross Loos/CIGNA	R
CAHP Prudent Buyer Plan	V
California Professional Firefighters Association	V
California Correctional Peace Officers Association	V
PERS-CARE	V
Peace Officers Research Association of California	V

If a beneficiary's coverage is with Equicor or Travelers and the plan is not administered through PERS, the cost avoidance codes would remain "Q" or "T" as stated in ACWDL 88-92.

If the beneficiary informs the county that he/she no longer has the cost avoidance coverage, the override procedures described in ACWDL 87-44 must be used to remove the cost avoidance code from MEDS. If the beneficiary's coverage is now with an insurance carrier that is not administered through PERS, refer to the procedures in ACWDL 88-92 for the appropriate coding of his/her Medi-Cal card.

Counties will receive the OHC Indicator Change Report (RCV 139-BR002) listing the beneficiaries coded as a result of the PERS match. Counties are not required to update their records to match MEDS. Because other health coverage information is printed on share of cost forms (MC 177), counties should update their MC 177 share of cost records to alert providers to a beneficiary's cost avoidance coverage prior to their rendering services.

If you have any questions regarding MEDS input, contact your MEDS liaison. All other questions should be directed to Michael Jimenez of the Health Insurance Unit at (916) 739-3262.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

Expiration Date: April 6, 1991

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY
DEPARTMENT OF HEALTH SERVICES
MEDICAL ASSISTANCE

IMPORTANT MEDI-CAL NOTICE

MEDI-CAL IS EXPANDING ITS PROGRAM FOR USING PRIVATE HEALTH INSURANCE. THIS PROGRAM IS CALLED COST AVOIDANCE AND IT MEANS THAT IF YOU HAVE PRIVATE HEALTH INSURANCE, MEDI-CAL WILL NOT PAY FOR MEDICAL SERVICES COVERED BY YOUR INSURANCE. HOWEVER, YOU WILL STILL BE ABLE TO USE YOUR MEDI-CAL CARD FOR MEDI-CAL COVERED SERVICES THAT YOUR PRIVATE HEALTH INSURANCE DOES NOT COVER.

OUR RECORDS INDICATE THAT YOU HAVE PRIVATE HEALTH INSURANCE ADMINISTERED THROUGH THE PUBLIC EMPLOYEES RETIREMENT SYSTEM (PERS). BEGINNING WITH YOUR APRIL 1990 MEDI-CAL CARD, EITHER A K, P, R OR V CODE WILL BE PLACED IN THE OTHER COVERAGE FIELD OF YOUR MEDI-CAL CARD TO INDICATE COVERAGE WITH ONE OF THE SPECIFIC PLANS WHICH CONTRACTS WITH PERS.

EFFECTIVE APRIL 1, 1990, IF YOUR MEDI-CAL CARD IS CODED WITH A "V", YOUR PROVIDERS WILL HAVE TO BILL YOUR PRIVATE HEALTH INSURANCE BEFORE BILLING MEDI-CAL. IF YOUR INSURANCE COMPANY DENIES PAYMENT, YOUR PROVIDER MAY THEN BILL MEDI-CAL.

IF YOUR MEDI-CAL CARD IS CODED WITH A "K", "P", OR "R", YOU HAVE BEEN IDENTIFIED AS HAVING HEALTH COVERAGE PROVIDED THROUGH A PREPAID HEALTH PLAN OR HEALTH MAINTENANCE ORGANIZATION. RECIPIENTS WITH THIS COVERAGE ARE REQUIRED TO GO TO THEIR SPECIFIC PLAN TO RECEIVE HEALTH CARE SERVICES. IF YOUR PREPAID HEALTH PLAN/HEALTH MAINTENANCE ORGANIZATION DOES NOT PROVIDE THE NEEDED SERVICE, YOU MUST REQUEST FROM THE PLAN, A "DENIAL LETTER" OR "EXPLANATION OF BENEFITS" CLEARLY STATING THAT THE SERVICE REQUESTED IS NOT COVERED UNDER THE TERMS OF YOUR HEALTH PLAN. PRESENT THE DENIAL LETTER OR EXPLANATION OF BENEFITS TO A MEDI-CAL PROVIDER AND HE/SHE WILL ATTACH THE LETTER TO YOUR MEDI-CAL CLAIM FOR SERVICE AND SUBMIT IT TO MEDI-CAL FOR REIMBURSEMENT.

IF THIS PRIVATE HEALTH INSURANCE COVERAGE EXTENDS TO A DEPENDENT, PLEASE COMPLETE THE ENCLOSED HEALTH INSURANCE QUESTIONNAIRE FOR ALL COVERED DEPENDENTS AND RETURN IT TO THE DEPARTMENT IN THE ENCLOSED POSTAGE PAID ENVELOPE.

IF YOU DO NOT HAVE PRIVATE HEALTH INSURANCE WITH THE PLAN THAT WE HAVE CODED ON YOUR CARD, CONTACT YOUR COUNTY WELFARE DEPARTMENT.